Private Healthcare Australia
Better Cover. Better Access. Better Care.

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Australian Competition & Consumer Commission

Report to the Senate on Private Health Insurance

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Introduction

The Australian Government is currently undertaking a number of reviews relating to private health insurance (PHI) aimed at improving value for consumers. Private Healthcare Australia (PHA) and its member health insurers see private health as part of the solution for delivering quality healthcare at an affordable cost.

The ACCC has identified inappropriate communication to consumers of policy changes which lead to 'bill shock' and inadequate coverage as the focus for its report this year. This submission addresses these concepts but it is important to note that this sort of dissatisfaction is not isolated to policy changes but more broadly experienced by consumers who simply purchase a PHI policy unsuited to their needs, experience an unexpected health event, or do not receive appropriate pre-treatment Informed Financial Consent (IFC) from their healthcare provider.

PHA and its members accept that there is a vast array of products available in the marketplace and that differentiating amongst them is not always easy. In part, of course, this is an inevitable result of an industry with more than 30 competitors actively seeking new customers. Each insurer typically offers several levels of hospital coverage, plus the option of various additional levels of general treatment cover. The *Private Health Insurance Act 2007* (the Act) and its subordinate regulations impose numerous requirements on insurers stipulating when and how to communicate with policy holders. Policy holder feedback suggests the statutory nature of these communications is not always useful, so insurers have responded by providing additional information in more user-friendly formats. Further to the requirements of legislation, the industry has established the Private Health Insurance Code of Conduct, which requires insurers to comply with a higher level of communication with members affected by a detrimental change to their policy.

When considering the causes of 'bill shock' and misunderstandings about the extent of PHI coverage, it must be acknowledged that some information, such as patient liability for gap payments to doctors, is simply not available to insurers before the patients receive their bills, and is completely at the mercy of doctors' billing practices. Despite this, 86.3% of all privately insured hospital services in 2014-15 resulted in no out of pocket expenses for the patient.

There has been substantial innovation in the design of health insurance products over time. The level of competitiveness in the market has led to an inherent trade-off between product proliferation and complexity as insurers seek to differentiate themselves by targeting specific consumer cohorts with tailored products. It would be possible to simplify the product range across insurers but this would reduce competition in the industry and result in many customers having to buy products that were not as well targeted to their needs.

Product switching is increasingly common. Third party comparators, such as iSelect and Compare the Market, are making comparison between insurers easier, yet many stakeholders are concerned about the lack of transparency around the third party comparator model and the impact this has on consumers' understanding of their PHI policy. Together, the insurers and the comparator sites are estimated to spend $100-150 million each year on advertising that promotes shopping and switching behaviour. In addition, industry initiatives and Government legislation facilitate portability across insurers.

Another cause of frustration for policy holders is the growing practice of public hospitals inducing patients to agree to be treated as a private patient. Public hospitals have devoted significant resources to increasing the proportion of private patients as a source of new funding in addition to allocations from state and federal governments, and the number of private patients treated in public hospitals has doubled since 2008. PHI policy holders often receive no additional benefit by being treated as private patients in public hospitals. The increasing trend towards more private patients in public hospitals introduces new risks for patients, including unexpected gaps. In addition, private health insurance benefits in public hospitals adversely impacts private health insurance members by increasing costs, which drives up premiums.

The industry has committed to launch a process to identify how aspects of the products, or the descriptions of products, can be standardised. The industry will seek solutions that improve the transparency and comparability of products while maintaining the highly competitive nature of the health insurance market. PHA is currently investigating options to improve transparency and comparability across the industry, including the Private Health Insurance Code of Conduct (the Code) as the preferred mechanism for implementation.

In the context of several current and ongoing policy review process affecting PHI, and the industry's proactive moves to address concerns relating to communicating policy changes, PHA recommends against any changes being made in isolation to the PHI Act or its subordinate regulations at this time.

Contents

About Private Healthcare Australia

Private Healthcare Australia (PHA) is the industry association representing Australia's private health insurance industry. Its member insurers provide over 95% of the policies 13.3 million private health insurance policies issued in Australia.

Communication with policy holders

Requirements of health insurers

The Act establishes minimum requirements for health insurers to communicate policy changes to affected members. Further the minimum requirements set out in the Act, the industry has established the Code, which binds all but two of Australia's health insurers and covers over 99% of policies issued. The Code covers four main areas of conduct in private health insurance:

1. Ensuring the correct information on private health insurance in provided from appropriately trained staff;
2. Promoting awareness of the internal and external dispute resolution procedures available in the event a consumer becomes involved in a dispute with an insurer;
3. Ensuring policy documentation contains all the information required to make a fully informed decision about the purchase and that all communications between policy holders and insurers are conducted in a way that the appropriate information flows between the parties. This includes staff, agents and brokers; and
4. Ensuring that all information between policy holders and insurers is protected in accordance with national and state privacy principles.

With respect to communicating policy changes to affected members, the Act requires insurers to maintain an up to date Standard Information Statement (SIS) for each product subgroup (S93) and to inform a member of a detrimental change to their policy "a reasonable time before the change takes effect" (S93-20 and 93-25).

The concept of "a reasonable time" is not defined nor is the method for initial communication of the change. In place of this, the Code stipulates that policy holders should be provided with 30 days' written notice ahead of any detrimental changes to hospital benefits, and 60 days' notice ahead of any significant detrimental changes to hospital benefits. For general treatment policies, the Code stipulates a minimum of 30 days written notice ahead of any significant detrimental change. The Code does not impose specific communication requirements on insurers in circumstances when changes to hospital contracting arrangements affect a policy holder in acknowledgement that "requirements for notification of consumers of such changes and transition arrangements are included in the relevant agreements and the Code of Conduct for Health Fund and Hospital Negotiations."[1]

The provisions of the Act for communicating detrimental changes combined with the relevant principles of the Code provides a sound framework for ensuring consumers are not mislead or deceived about what their policy covers. If an insurer complies with this framework, any policy holders affected by a detrimental change will be informed with at least 30 days' notice of the change taking effect. Since legislation also provides portability rights, any informed policy holder is provided with ample opportunity to switch to an alternative insurance policy before they are affected.

Industry practice

In practice, insurers are in frequent communication with policy holders over the course of a membership year. Insurers are required by various regulations to communicate with customers at certain times, including:

[1] *Private Health Insurance Code of Conduct, July 2014, Version 5*

- Providing a private health insurance tax statement containing information required for income tax returns to each adult covered by a policy in July each year.
- Providing notice of changes in premiums, typically provided in March ahead of a 1 April premium change.
- Providing a SIS at least once every 12 months, and at any point during that period when the policy is changed by either the insurer or the member.

The need for these communications materials to comply with regulatory requirements generally results in the content being less likely to be absorbed by the policy holder than other types of personalised information. To keep policy holders up to date with and aware of their policy, insurers go above and beyond the mandated requirements of the Act and Code. Typically insurers will provide each member with a summary document explaining their policy in layman's terms, and access to online and telephone services offering product information including coverage, benefits, waiting periods etc. All insurers have documents available for policy holders preparing to go to hospital containing information on what questions to ask providers and how to reduce or eliminate out of pocket expenses. A number of insurers operate retail outlets that can be visited by prospective and existing policy holders for claiming and accessing coverage information. Insurers also conduct member satisfaction surveys that attempt to identify potential improvements to products, services or communication to eliminate policy holder confusion. Insurers will periodically contact policy holders who remain on older policies that are no longer marketable to discuss whether their policy still meets their needs.

What constitutes a policy change?

PHA notes the ACCC's concerns about the adequacy of current requirements regarding communicating policy changes, which raises the question of what is meant by 'policy change'. Unlike other forms of insurance which are limited to a defined term, PHI is a continual product, which means policy changes are an essential part of the industry. Advancements in medical technology, new research on the effectiveness of treatments, changes in Government reimbursements (MBS), and changes in population health and claiming profiles are all factors that contribute to insurers needing to make adjustments from time to time to continue meeting the needs of policy holders at an affordable price.

The Act defines a complying health insurance policy as "insurance policy that covers hospital treatment or general treatment or both" for an individual. Section 63-10 further specifies the legislative standards that a complying private health insurance policy must meet, including what it can and cannot cover.

Under this framework, insurers design policies covering specific hospital or general treatment services and determine the benefit payable to policy holders within the product schedules contained within the insurer's rules (as set out in s169-10 and s93-20 of the Act). A policy change is therefore any change affecting the benefits payable under a policy according to the insurer's rules, which can range from major changes (such as removing coverage for a particular hospital treatment) to minor changes such as how or when a policy holder can suspend their membership. Changes in contracting terms with particular healthcare providers do not necessarily result in a change in the insurer's rules.

What is bill shock?

Bill shock in healthcare occurs when a patient becomes liable for out of pocket costs relating following their treatment. The ACCC's focus in this report is how communication from insurers can impact on bill shock experienced by policy holders, but it is important to note that there are many causes of bill shock which cannot be overcome by insurer communication alone, including:

- Consumers failing to understand the coverage and benefits provided by their PHI policy.
- Doctors failing to provide appropriate informed financial consent (more information on IFC is provided later in this submission).
- Complications that occur during a procedure that can lead to additional charges being incurred.
- Occasions where fees charged by healthcare providers are excessive.

The industry is committed to improving the information it provides to policy holders and helping as much as possible to help policy holders to navigate the complex healthcare system, but insurers alone cannot eliminate bill shock entirely while the above factors continue to occur.

Industry initiatives to improve consumer information

PHA is currently working with the Commonwealth Ombudsman and the Department of Health on an initiative to both improve the content of the SIS and streamline it so that it can be better incorporated into insurer-based IT systems. As currently constructed, the SIS is not a useful comparison tool for consumers or insurers as its format and content is quite restrictive in nature. The aim of the improvement initiative is to provide clearer information to consumers about their policy through the SIS. This will enable insurers to provide better advice to policy holders on how to select policies appropriate for their needs, as well as facilitate faster/smoother transfers of policy holders between insurers when switching from one insurer to another.

Insurers have taken steps to make their products simpler to understand by offering products with no exclusions, restrictions and the best possible gap protection. While this makes products simpler and easier to compare, it also makes premiums more expensive. Cuts to the PHI rebate in 2013 have resulted in a growing majority of insured consumers choosing products with exclusions, front-end deductibles or restrictions in order to reduce their premiums as far as possible. PHA notes that consumers' ability to do this is restricted by regulations capping the level of excesses (which are not indexed and therefore erode in value relative to the policy premium each year). This treatment of excesses has exacerbated the trend towards policies with exclusions and restrictions of coverage for those consumers who choose to share with their insurer some of the risk of incurring healthcare costs in order to receive lower annual premiums.

On behalf of the industry, PHA has initiated an independent review of consumer communications with the aim of identifying opportunities to harmonise terminology and increase consistency of interpretation across all insurers. This will assist consumers to understand the benefits of their policy and compare between insurers.

As reported across mainstream media outlets in recent months, some insurers have responded to substantial variation in medical fees by publishing charges levied by specialist doctors[2][3], giving policy holders some basis for comparison and negotiation, facilitating an improved understanding how to avoid incurring out of pocket health costs and, hopefully, reducing incidents of bill shock.

The industry has acknowledged the concerns about communicating policy changes raised by the ACCC in last year's report and has included a proposal to strengthen the relevant section of the Code as part of the regular review process undertaken by the Code Committee. The proposed changes, currently awaiting formal endorsement, will require insurers to provide consumers with more specific information on any changes to their policy, being made in plain language and in a format aimed to assist comprehension by consumers. A similar amendment is also proposed for the Code's Self-Audit Guide.

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[2] *Bupa goes after high charging surgeons* – Australian Financial Review, 16 December 2015

[3] *NIB puts heat on surgeons by exposing fees* – Australian Financial Review, 15 February 2016

Difference between PHI and other forms of insurance

When considering the consumer experience it is important to note the significant degree of legislative consumer protections that apply to PHI which do not exist in other forms of insurance, such as motor vehicle insurance, life insurance or home and contents insurance. Some of these consumer protections include:

- The concept of portability, which allows policyholders to change their level of cover or switch to another insurer without the need to re-serve waiting periods, provided they switch to an equivalent or lower level of cover. In the context of the minimum 30 day notice period for policy changes, this provides policyholders with adequate opportunity to change their level of cover or switch insurers and maintain coverage.
- Community rating, which prohibits an insurer from refusing to insure a policyholder or discriminating on the basis of health risk or claiming history. Insurers must provide cover for everyone who seeks it at the same price regardless of risk profile.
- Unlike other insurances PHI is not term limited. In a term limited insurance product the insurer can introduce changes at the end of the term, whereas in PHI the product is continual. Therefore private health insurers require the ability to change policy terms during the life of the policy.

Healthcare transparency and information asymmetry

The industry is willing to play its part in working to provide the best information possible to consumers, but the Australian healthcare system that is complex by nature and many sources of confusion and dissatisfaction are outside the control of insurers.

By the time a policy holder has made a claim for hospital care from their insurer, they have most likely already been in contact with several different healthcare providers over an extended time period. Some of these will be public health providers whose services are delivered at no cost to the patient, while others will be private providers outside the permitted scope of PHI (so the patient pays out of their own pocket), while services provided in hospital may be paid for by PHI.

The Australian healthcare system, including private health insurance, is also subject to extensive government regulation which, while well intentioned and often necessary, adds to complexity.

In addition to system complexity and red tape, the lack of access for consumers to important information on healthcare providers hinders quality and cost outcomes in a number of ways. For example, patients requiring specialist medical treatment often rely on their General Practitioner to refer them to an appropriate specialist, yet there is no registry or resource available for GPs (let alone patients) to easily determine the most appropriate specialist for a particular patient on the basis of fees charged, location, experience, medical devices used, hospital, etc.

Patients find it difficult to make choices about the type of treatment that is most appropriate to their circumstances, including their level of insurance coverage. When adequate information as to the costs and possible consequences of various treatment options are presented to patients they often opt for less invasive, lower cost treatments.

The fragmented nature of treatment pathways and passive attitudes caused by information asymmetry results in patients relying excessively on their provider to assist them in navigating the healthcare system. This can unfortunately lead to unexpected outcomes with regard to cost and coverage when private health insurance is involved.

Failure to provide Informed Financial Consent

Informed financial consent (IFC) occurs when private patients receive relevant cost information about their treatment prior to the treatment taking place. IFC is important as it allows patients to make informed decisions about their healthcare and any costs they will be liable to pay.[4]

In 2015 86.3% of hospital services paid for using PHI were provided with no gap paid by the patient.[5] Despite this, patients facing unexpected costs following treatment is a source of frustration for policy holders, often directed at the health insurer rather than the provider.

Market research has found one in five hospital treatment gaps (when they occur) exceed $1000, and that dissatisfaction increases as gaps rise above $500. Failure to provide patients with Informed Financial Consent (IFC) remains a significant source of dissatisfaction with hospital treatment for private health insurance policy holders. Despite several initiatives aimed at increasing IFC compliance, only one in three patients who report out of pocket hospital costs were informed about these costs prior to their treatment.[6]

Insurers have developed materials with the aim of assisting policy holders to understand they have the right to ask questions about their treatment, including about any costs payable over and above the benefits of their PHI policy. Despite this, many policy holders are either unwilling or unable to obtain this information from their healthcare provider. This can lead to the policy holder being dissatisfied with the quantum of out of pocket costs related to their treatment.

The role of third-party comparators

Third-party comparators provide the opportunity for consumers to compare certain private health insurance policies on the basis of price or certain other criteria such as excess levels. The model has been successful in the market, with almost 20 per cent of all private health insurance policies now sold through online comparators who spend an estimated $100-150 million per year on advertising to consumers encouraging insurer switching. While this has driven competition in the PHI industry and reduced barriers to entry, there are serious concerns regarding the lack of regulation covering the conduct of online comparator websites, including:

- The Australian Medical Association has said "there should be more scrutiny from Government and regulators as to whether this practice is distorting the market even further, including through reduced transparency. Further scrutiny is also required as to whether these comparators unnecessarily focus on price rather than health needs. The expansion of these sites, which provide information on only a small range of products, could also be adding to consumer confusion"[7]
- The consumer advocate, Choice, investigated online comparators across various types of insurance products and found "apart from Canstar, all the sites we looked at compare policies and provide quotes from a third (or less) of all health insurance providers."[8]
- In its November 2014 report on online comparators across various types of insurance, the ACCC noted its concerns about the conduct of comparators in the private health insurance market, including occasions where it had taken successful action against major providers. The report also noted concerns regarding inadequate disclosure that "a comparator website earns some or all of its revenue from leads or sales under commercial relationships with service providers whose products it compares and the nature and extent of the comparison service is

[4] Productivity Commission – *Public and Private Hospitals: Research Report*, December 2009
[5] Australian Prudential Regulation Authority – *Private Health Insurance Membership and Benefits*, December 2015
[6] Ipsos – *Health Care and Insurance Australia 2015*
[7] Australian Medical Association – *Private Health Insurance Report Card 2016*
[8] Choice – *Insurance comparison sites – Review*, 19 August 2014

entirely or largely based on which service providers a comparator website operator has commercial relationships with."[9]

While the ACCC has subsequently released a best practice guide for comparators and provided information for consumers on how to use comparator websites, the issue of undisclosed commissions continues to be of serious concern as the model evolves. The recent example of One Big Switch, being sponsored by News Corporation and promoted extensively in its stable of newspapers and online outlets, is a different model of third party agent and there is a need to consider its influence over consumer purchasing decisions.

Limited product coverage

As noted by Choice, PHI comparators present products to consumers from a small minority of insurers. A listing is dependent on the insurer entering into a commercial relationship with the comparator. Even among the limited policies listed for comparison, there is significant uncertainty regarding the criteria used by comparators in devising their rankings of policy suitability. This has caused many stakeholders to be concerned about the extent to which the recommendations of comparators are motivated by commercial factors rather than the needs of consumers.

Inappropriate product advice

Based on the advice they receive provided by comparators, consumers may be purchasing insurance products that do not meet their needs, potentially exposing them to significant and unexpected medical costs in the future.

No transparency of commissions

The absence of any regulation preventing insurers paying comparators commissions of up to 40% of the value of the policy is at odds with the PHI Act preventing the heavy discounting of health insurance policies. Because commissions received by comparators vary across insurers, comparators have a greater incentive to promote policies that will generate higher revenue than the incentive to meet the needs of consumers.

The lack of requirements for PHI comparators to disclose commissions received is at odds with the principles of the Future of Financial Advice (FoFA) reforms, which prohibit financial advisers from receiving payments (including commissions) that could influence financial product recommendations. PHA does not recommend a prohibitive approach to commissions in PHI, but there is a case for commission disclosure to provide consumers with the information they require to make informed choices.

Private patients in public hospitals

An increasing source of consumer confusion and bill shock in PHI is the practice of public hospitals to persuade patients to agree to be treated as a private patient. Public hospitals have devoted significant resources to increasing the proportion of private patients as a source of new funding in addition to allocations from state and federal governments.

Private patient episodes in public hospitals reached 736,237 in 2014-15 and have nearly doubled since 2007-08. Over this period, private patient episodes in public hospitals have increased by 81%, an average increase of 9% per annum. Private patient episodes in public hospitals now represent 18% of all hospital treatment episodes that paid for by PHI in 2014-15.[10]

The increasing trend towards more private patients in public hospitals introduces new risks for patients, including unexpected out of pocket costs. PHI policy holders often receive no clear benefit by being treated as private patients in public hospitals and some are not aware they are entitled to be treated free of charge if admitted to a public hospital. Private patients in public hospitals are less likely to be

[9] Australian Competition & Consumer Commission – *The comparator website industry in Australia*, November 2014

[10] Australian Prudential Regulation Authority – *Private Health Insurance Membership and Benefits* publications

pre-informed about their out of pocket costs than private hospital patients. While many public hospitals offer gap-free treatment as part of their inducement for patients to use their PHI, around one in five private patients treated in public hospitals end up being liable for out of pocket payments, 39% of whom reported being surprised by the amount they were left to pay.[11] In addition, private health insurance benefits in public hospitals adversely impacts policy holders by increasing costs, which drives up premiums.

Conclusion

Private health insurance carries some inherent complexities as a result of Government regulation and the fragmented nature of Australian's healthcare system that means some consumers will misunderstand their coverage from time to time. Despite the industry's legitimate attempts to provide tailored, targeted communication to policy holders about their policy and benefits, there are a number of factors beyond the control of insurers that cause dissatisfaction following treatment.

In the context of several current and ongoing policy review process relevant to PHI (which are likely to address the types of consumer experiences that are the focus of the ACCC's report), and the industry's proactive moves to address concerns relating to communicating policy changes, PHA recommends against any changes being made in isolation to the PHI Act or its subordinate regulations at this time.

[11] Ipsos – *Health Care and Insurance* Australia *2015*